BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GLENDA DE GUZMAN BISCOCHO** a.k.a. **GLENDA MAGTIBAY DE GUZMAN** 206 Tinley Avenue Depue, IL 61322 Registered Nurse License No. **628971** Respondent	Case No. 2011-806

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on **June 24, 2011.**

IT IS SO ORDERED **June 24, 2011.**

Jeannie K. Graves

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GLENDA DE GUZMAN BISCOCHO, A.K.A., GLENDA MAGTIBAY DE GUZMAN** **206 Tinley Avenue** **Depue, IL 61322** **Registered Nurse License No. RN 628971** Respondent.	Case No. 2011-806 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) is the Executive Officer of the Board of Registered Nursing. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Karen R. Denvir, Deputy Attorney General.

2. Glenda De Guzman Biscocho, a.k.a., Glenda Magtibay De Guzman (Respondent) is representing herself in this proceeding and has chosen not to exercise her right to be represented by counsel.

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3. On or about November 7, 2003, the Board of Registered Nursing issued Registered Nurse License No. RN 628971 to Glenda De Guzman Biscocho, a.k.a., Glenda Magtibay De Guzman (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought in Accusation No. 2011-806 and will expire on February 28, 2011, unless renewed.

JURISDICTION

4. Accusation No. 2011-806 was filed before the Board of Registered Nursing (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 24, 2011. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 2011-806 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 2011-806. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 2011-806, agrees that cause exists for discipline and hereby surrenders her Registered Nurse License No. RN 628971 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Registered Nurse License without further process.

CONTINGENCY

10. This stipulation shall be subject to approval by the Board of Registered Nursing. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Registered Nursing may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

11. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

12. This Stipulated Surrender of License and Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Surrender of License and Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

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ORDER

IT IS HEREBY ORDERED that Registered Nurse License No. RN 628971, issued to Respondent Glenda De Guzman Biscocho, a.k.a., Glenda Magtibay De Guzman, is surrendered and accepted by the Board of Registered Nursing.

1. The surrender of Respondent's Registered Nurse License and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Registered Nurse in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 2011-806 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If and when Respondent's license is reinstated, she shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $5,098.66. Respondent shall be permitted to pay these costs in a payment plan approved by the Board. Nothing in this provision shall be construed to prohibit the Board from reducing the amount of cost recovery upon reinstatement of the license.

6. Respondent shall not apply for licensure or petition for reinstatement for two (2) years from the effective date of the Board of Registered Nursing's Decision and Order.

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ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Registered Nurse License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: 4/19/2011

Glenda J. Biscocho

GLENDA DE GUZMAN BISCOCHO, A.K.A.,
GLENDA MAGTIBAY DE GUZMAN
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

Dated: April 21, 2011

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ARTHUR D. TAGGART
Supervising Deputy Attorney General

Karen Denvir

KAREN R. DENVIR
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 2011-806

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GLENDA DeGUZMAN BISCOCHO** **aka GLENDA MAGTIBAY DeGUZMAN** 143 Cathcart Avenue Sacramento, California 95838 **Registered Nurse License No. 628971** Respondent.	Case No. 2011-806 **ACCUSATION**

Louise R. Bailey, M.Ed., RN ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about November 7, 2003, the Board issued Registered Nurse License Number 628971 to Glenda DeGuzman Biscocho, also known as Glenda Magtibay DeGuzman ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein. The license expired on February 28, 2011, and has not been renewed.

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STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

7. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

BACKGROUND INFORMATION

SEPTEMBER 23, 2009

9. Between September 23, 2009, and September 24, 2009, while employed as a Clinical Nurse II at U.C. Davis Medical Center, located in Sacramento, California, Respondent was assigned to care for a patient who was on an intravenous heparin drip due to the risk of developing blood clots following an aortobifem bypass. While caring for the patient, Respondent did the following:

a. On two occasions, Respondent completely turned off the patient's heparin drip without a physician's order, rather than placing the heparin drip on hold. By placing the heparin drip on hold, it would beep as a reminder to turn it back on. As a result of turning the heparin drip completely off, it was determined that the heparin pump was off for approximately 10 minutes on one occasion, and approximately one hour on a second occasion. Respondent did not document the interruption of the infusion in the patient's medical records.

b. Respondent drew the patient's blood for a PTT (partial thromboplastin time).[1] When Respondent drew the patient's blood, she drew it from the patient's central line instead of from a peripheral vein, resulting in an abnormally high reading of 123.8.[2] As a result of that reading, the physician ordered that the heparin drip rate be decreased. Respondent did not question the physician regarding why the heparin drip rate was lowered when the PTT was extremely elevated. When Respondent discovered that she had made an error by drawing the patient's blood from the patient's central line rather than from the peripheral vein, she failed to notify the physician and

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[1] Partial thromboplastin time (PTT) is a blood test that determines how long it takes for blood to clot.

[2] A normal PTT reading is between 45 and 55.

charge nurse of the error, thereby allowing the heparin drip to remain at the decreased rate. Respondent then drew another PTT without a physician's order. Respondent also failed to document the blood draw error.

c. Respondent failed to discontinue the patient's central line as ordered by the physician, thereby putting the patient at risk for a blood stream infection. Respondent failed to document the patient's request to keep the central line in place, and failed to document educating the patient of the increased risks of a blood stream infection when leaving the central line in place.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

10. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of unprofessional conduct, in that between September 23, 2009, and September 24, 2009, while a Clinical Nurse II at U.C. Davis Medical Center, located in Sacramento, California, she was incompetent within the meaning of California Code of Regulations, title 16, section 1443, as more particularly set forth below:

a. Respondent failed to draw the patient's blood from the proper location (peripheral vein), resulting in an abnormally high PTT level reading.

b. Respondent failed to recognize the cause of the abnormally high PTT level.

c. Respondent failed to notify the physician of the blood draw error and have the infusion rate adjusted accordingly.

d. Respondent failed to remove the patient's central line as ordered by the physician.

e. Respondent failed to recognize the patient's increased risk of a blood stream infection when leaving the patient's central line in place.

f. Respondent failed to educate the patient regarding the increased risk for a blood stream infection when leaving a central line in place.

g. Respondent failed to provide the physician with a complete accounting of the patient's treatment.

h. Respondent turned off the patient's heparin drip twice without a physician's order.

i. Respondent drew the patient's blood without a physician's order.

BACKGROUND INFORMATION

MAY 10, 2009

11. Between May 10, 2009, and May 11, 2009, while employed as a Clinical Nurse II at U.C. Davis Medical Center, located in Sacramento, California, Respondent was caring for a patient who was suffering from diabetes and renal failure. On May 10, 2009, at approximately 2000 hours, Respondent assessed the patient. The patient's blood pressure was 86/52 (hypotension) with a heart rate of 90. Over six hours later (May 11, 2009, at approximately 0200 hours), Respondent returned to the patient's room to take the patient's vital signs. Respondent found the patient lethargic, cold, clammy, unresponsive to verbal stimuli, and a weak pulse. Because the patient suffered from diabetes, Respondent decided to check the patient's blood sugar level to determine if the patient was suffering from a diabetic reaction. Respondent left the patient's room to obtain the blood sugar testing equipment (glucometer). While returning to the patient's room with the blood sugar testing equipment, Respondent told her colleague, R.O., that she needed assistance. Respondent pricked the patient's finger to test the blood sugar levels, and tried to reposition the patient. While repositioning the patient, Respondent discovered that something was wrong with the patient. At that point, R.O. entered the patient's room, but the room was dark, making it difficult to see. R.O. turned on the lights and found the patient slumped over toward the side rail. R.O. performed a stimuli rub with no response. R.O. assessed the patient's pupils, discovered they were fixed and dilated and the patient was in cardiac arrest, and called a code blue.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

12. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of unprofessional conduct, in that between May 10, 2009, and May 11, 2009, while employed as a Clinical Nurse II at U.C. Davis Medical Center, located in Sacramento, California, she was grossly negligent in the following respects:

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a. Respondent failed to notify the physician of the patient's initial hypotension at 2000 hours on May 10, 2009, and failed to repeat the blood pressure measurement.

b. At the 0200 hour assessment on May 11, 2009, Respondent failed to adequately protect the patient from a life threatening event as follows:

i. Respondent failed to active a code blue upon finding the patient cold, clammy, and unresponsive.

ii. Respondent failed to ensure proper lighting in the room to make an accurate assessment of the patient upon finding the patient cold, clammy, and unresponsive.

iii. Respondent failed to recognize the seriousness of the patient's condition upon finding the patient cold, clammy, and unresponsive, and left the patient's room to retrieve diabetic equipment. While retrieving the diabetic equipment, Respondent asked R.O. for assistance with the patient without conveying the seriousness of the patient's condition.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

13. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct, in that between May 10, 2009, and May 11, 2009, and between September 23, 2009, and September 24, 2009, while employed as a Clinical Nurse II at U.C. Davis Medical Center, located in Sacramento, California, Respondent demonstrated unprofessional conduct, as more particularly set forth above in paragraphs 10 and 12.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 628971 issued to Glenda DeGuzman Biscocho, also known as Glenda Magtibay De Guzman;

2. Ordering Glenda DeGuzman Biscocho, also known as Glenda Magtibay De Guzman, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/24/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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